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ABSTRACT

The Health Consumer Education Program (CEP) was designed to foster "maximum feasible participation" of the people in planning, administering, and implementing community health care programs through adult education. This report, an analysis and evaluation of CEP, describes the program, presents data on intended and current practice, analyzes discrepancies and discusses recommendations using data obtained from interviews with key CEP staff, community participants who served as course coordinators, evaluation sheets completed by all course participants, questionnaires (Appendixes A and B) mailed to course participants, observation of a few classes, and analysis of documents (proposals, progress reports, course outlines). The community participation on the steering committees in all four low-income areas created a broad range of learning experiences and articulated the needs of the communities. Comparing the summary of program intent with the survey results from the questionnaires (115 responses, reflecting a 34.6 percent response rate) and interviews, it was found that there were no discrepancies between the goals and actual practice. Recommendations pointed out several weaknesses: the need to recruit more community leaders, more emphasis on application of skills and knowledge, more technical assistance for projects, and the institution of continuous program evaluation from the inception of the program. (JB)

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EDUCATION FOR COMMUNITY PARTICIPATION
IN HEALTH DECISION MAKING:
AN EVALUATION OF COLUMBIA UNIVERSITY'S
CONTINUING EDUCATION PROGRAM
FOR HEALTH CONSUMERS

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Introduction

Two years ago, in July, 1972, the Program in Continuing Education, School of Public Health, Columbia University, received a project grant from the Health Resources Administration, Public Health Service, Department of HEW, to provide educational programs for New York City health consumers so that such persons would be better equipped to participate in community health care planning as mandated by federal comprehensive health planning legislation.

The philosophy underlying the federal initiative in comprehensive health planning seems to echo the egalitarian dictum of the now moribund War on Poverty: "Maximum feasible participation" of the people in community health care planning. The grant proposal submitted by Columbia University incorporated an educational philosophy very much in harmony with the maximum feasible participation thrust of public policy. It was proposed that major responsibility for the planning and implementation of educational programs for health care consumers would rest with the consumers themselves. The University would provide assistance, notably money and staff expertise, but the burden of responsibility for assessing educational needs, setting objectives, and implementing programs was to be assumed by the community residents themselves. The project proposal, developed in collaboration with seven community health planning units (experimental forerunners of community health planning boards), set forth the following objectives:

To help citizens recognize their health rights, gain confidence in the importance of their role as consumer representatives, learn to articulate the health needs of their community and develop both planning and administrative skills.

The present report is an analysis and evaluation of this unusual experiment in community education.

Evaluation Design

This evaluation is largely an ex post facto analysis of the Health Consumer Education Program (CEP). Funds were not available for a two-year continuous evaluation, which all parties agree would have been highly desirable and certainly more helpful in providing feedback for program improvement purposes.

The major shortcoming of an ex post facto design, from the traditional research point of view, is the grave difficulty one encounters in trying to ascertain program effects without the benefit of experimental or quasi-experimental controls. Thus, the argument runs, how can one be sure that observed outcomes of a program are due to the program itself and not to some extraneous factor(s) unless one makes pre- and post-treatment observations on both experimental and control groups?

We concur that it is impossible to determine cause and effect relationships in the absence of rigorous experimental controls. But, as Weiss and Rein point out, attempts to apply experimental designs in the evaluation of complex social programs usually prove futile because such programs are constitutionally resistant to the requirements of precise measurement and experimental manipulation.¹ Furthermore, experimental or quasi-experimental designs, which necessarily emphasize input and output measures, provide little information about the process of program planning and implementation. It does little good to know that a program has succeeded or

¹Robert Weiss and Martin Rein, "The Evaluation of Broad-Aim Programs; A Cautionary Case and Moral," The Annals of the American Academy of Political and Social Science, Vol. 385, 1969.

failed without knowing why.

In our view, it is necessary to shift the terms of the discussion and to abandon the chimera of cause and effect in evaluating complex educational programs. If we assume that the purpose of the evaluation is to provide information for program improvement purposes (so-called formative evaluation), then the key question is: To what extent is the program accomplishing what it seriously intends to accomplish? It follows, therefore, that the evaluator (1) first establishes program intent; (2) subsequently collects data to determine current practice; and (3) compares data on intent with data on current practice to ascertain the nature and extent of any discrepancies. Should the evaluation reveal major discrepancies, those responsible for the program can modify current practice and/or adjust intents in order to close the gaps.

This approach to program evaluation, often termed "discrepancy analysis," was articulated in its basic outlines by Robert Stake of the University of Illinois in 1967.¹ The present investigators have employed discrepancy analysis in evaluating adult basic education programs.²

Overview of Evaluation Procedures

Subsequent sections of this report describe the Columbia University Health Consumer Education Program, present data on intended and current practice, analyze discrepancies, and discuss recommendations. Sources of data included interviews with key CEP staff, interviews with community

¹Robert Stake, "The Countenance of Educational Evaluation," Teachers College Record, Vol. 68, April 1967.

²See Alan B. Knox, Jack Mezirow, Gordon G. Darkenwald, and Harold Beder, An Evaluation Guide for Adult Basic Education Programs, Washington, D.C.: U.S. Government Printing Office, 1974.

participants who served as course coordinators, evaluation sheets completed by all participants for every course, a questionnaire mailed to all course participants, observation of a small number of classes, and analysis of documents such as the original proposal, progress reports, and course outlines.

Intent was established by interviewing the project director and the two assistant directors. They were asked to describe intended outcomes, not necessarily as set forth in the initial proposal, but rather as they had evolved through experience and reality testing. Similarly, they were queried about intentions related to program process factors such as extent and nature of participant responsibility for course planning. Reference will be made to intent as reflected in the official proposal, but the criterion of judgment is intent as determined by consensus of the three key staff members. It might be noted that there are often differences in intent among major actors in a program, and that such differences, which may be the source of serious problems are normally brought to light in discrepancy evaluation. In the present case, however, there were no significant differences in intent among the three program administrators. It should be noted, too, that the intents of community residents who helped plan and implement the courses were not taken into account in this evaluation. The reason for this omission is that involvement of any one community resident was limited to particular courses in a particular neighborhood. Our task was to evaluate the total program, which ultimately was the responsibility of the CEP staff.

Current practice, with emphasis on program process and outcomes, was assessed mainly through interviews with course coordinators in each of the target communities and through a questionnaire survey (see Appendix A) of

the 332 individuals who participated in CEP courses.

The course coordinators were a very important source of information about CEP. About a dozen community residents in the two-year period served as coordinators in the four target communities. The coordinators were chosen by the course steering committees, which consisted of local residents who volunteered to organize and plan the courses. In effect, the local coordinator was chairman of the steering committee and had the major role in actually conducting the classes, e.g., locating space to meet, contacting potential faculty, introducing speakers. Four coordinators and one steering committee member were selected for in-depth, open-ended interviews. Two were selected from the Harlem community (much of the action was in Harlem) and one each from Central Brooklyn and Williamsburg-Greenpoint. The steering committee member participated in the program conducted in the Lower East Side.

Following interviews with CEP staff, examination of the project proposal and other documents, and observation of classes in Harlem, a brief questionnaire was developed (see Appendix A) and mailed to all 332 CEP participants with a cover letter (Appendix B) signed by the CEP staff. After a follow-up appeal, usable returns were received from 115 participants, 34.6 percent of the total.

The response rate was less than we had hoped to achieve, but about average for a mail questionnaire. Two factors appeared to be of particular significance in suppressing the response rate. Many participants in CEP were poor and undereducated. Our own observations, confirmed by the staff, suggested that a significant percentage were barely literate. Inspection of open-ended responses from those who returned questionnaires indicated that many could write only with great difficulty. Although the questionnaire was deliberately designed to mitigate this problem (it was brief and simply worded), there is little doubt that a large number of CEP participants could complete the instrument only with great difficulty, if at all.

Poor people also tend to be very mobile and difficult to reach by mail or telephone. Sixty-two questionnaires were returned as undeliverable with such notations as "moved--left no address," "addressee unknown," and "unclaimed." Thus, we received responses from about 42 percent of those who could be reached by mail.

In order to estimate the probable direction of non-response bias, the first wave returns (n=78) were compared on all variables with the second wave returns (n=37). The reasoning behind this procedure is that those who are more difficult to reach (i.e., those who returned questionnaires only after a follow-up appeal) are more likely to possess certain characteristics in common with non-respondents. We did find some differences. Second wave respondents saw the community as having less say in designing and running the courses than did their counterparts. Moreover, a larger proportion of the second wave group indicated that CEP was of little help in improving their ability to "participate effectively in community health care decision making." Finally, there was a strong trend (but not statistically significant) for second wave respondents to indicate less involvement in community health affairs as a result of participation in CEP. Taken as a whole, these differences suggest that the second wave group, and by extrapolation the non-respondents, tended to be somewhat more skeptical about CEP--or perhaps critical of the University's influence in the community. However, on every variable not mentioned above, including learning gains and recommendation of the course to others, no difference was found between first and second wave respondents. Perhaps the non-respondents were generally negative for one reason or another. In any event, generalizations based on a 35 percent response rate must be considered tentative because of the possibility of significant non-response bias.

The main purpose of the questionnaire was to obtain data from participants about their perception of CEP process (e.g., how courses were planned and implemented) and outcomes (knowledge and skills, involvement in community health care activity). After coding of open-ended items, the questionnaire data were keypunched and verified and frequency and percentile distributions for each variable were generated by computer. Further analysis consisted of two-way cross-tabulations between selected variables such as reason for enrolling and extent of subsequent participation in community health care decision making. The Chi Square statistic was used to determine statistical significance of the cross-tabulated data, with alpha set at .05.

Because the study did not begin until the last month of CEP's grant period, it was not possible for the evaluators to systematically observe a representative sample of classes. Direct observation is a valuable strategy in process oriented evaluations, but the exigencies of time and money precluded its use in the present case. Lack of opportunity for systematic observation was, in our judgment, an unfortunate and serious limitation of the present study.

Description of the Columbia Health Consumer Education Program

Columbia University's Health Consumer Education Project has gone about its task of providing education for community residents within the context of a politically charged and highly complex network of agencies and organizations representing health consumers and New York City's health planning bureaucracy (known as the B Agency). The politics of comprehensive health planning (CHP) are well beyond the ken of this evaluation. It is germane to note, however, that the political context of consumer participation

in CHP adversely affected the University's ability to mount and sustain effective programs targeted on actual health decision makers. The original grant proposal called for education of consumer and provider members of local CHP boards, of which there were to be 33 in the city of New York. The idea was to help these local health decision makers (especially the consumer laymen) to effectively discharge their responsibilities by providing education related to health problems and the health care system and to the responsibilities and tasks of board membership. But when the project got underway in the summer of 1972 the local CHP boards had yet to be named. In fact, New York City's B Agency did not designate any local CHP boards until January, 1974, six months before the CEP project was scheduled to terminate. As a result of these developments, the CEP staff was obliged to shift the focus of the program to provide consumer education to local community residents who were interested in or involved in health care matters and who might at some later date become members of a local CHP board.

The past two years have been marked by controversy between the B Agency and various community health groups about the composition and powers of the yet-to-be-named CHP boards. There has also been conflict among the various health groups and agencies in the community. There is a widespread belief among community health activists that the B Agency has no intention of delegating real power to local CHP boards. One consequence of the pervasive strife is that CEP often found itself in the middle of the cross-fire.

The organization and functioning of the actual program is described here only in its barest outlines to provide the reader with a frame of reference for interpreting the evaluation findings and recommendations.

A detailed description of CEP's work in Harlem, co-authored by CEP staff and local community participants, can be found in a recent paper.¹

The CEP staff consisted of three professionals, two of whom devoted full time to the project. The third, the project director, was also director of Continuing Education in the School of Public Health and had other responsibilities in addition to CEP. All three staff members had had some experience in community development work. One assistant director was trained in social work, the other in public health. The director had a background in public health and adult education.

The community development and adult education backgrounds of the staff proved highly significant for the direction the project took. A cardinal principle of adult education theory, which is seldom found in practice, is that adults should take major responsibility for their own learning. It follows from this theory that the "teacher" does not frame lesson plans and instruct students, but rather serves as a resource person in assisting the learners to plan and implement their own educational activities. It is assumed that adults learn best not as passive absorbers of knowledge, but as active agents who take the initiative for the design and implementation of their own learning experiences. Aside from assumptions based on adult education theory, this approach had at least two very pragmatic advantages in the case of CEP. First, it would not have been possible for Columbia University to go into a community such as Harlem and simply announce that a course in health education would be given and distribute the syllabus. If the University was to have any hope of success, it would have to work

¹Marcia Heller, et al. "Consumer Planned Education in Comprehensive Health Planning." Paper presented at the annual meeting of the American Public Health Association, San Francisco, November, 1973.

collaboratively with the community to assess learning needs and plan and implement programs to meet those needs. Moreover, how would the staff of CEP know what to include in a pre-determined course syllabus? A second benefit of the "adult education approach" was that the program itself provided a model and learning experiences that were directly related to the ultimate objective of involving community residents in assessing community health care needs and in planning for more effective health care delivery systems. The latent lesson was this: "If you can plan and implement a health education program for the community, then surely you will be able to plan and implement programs for improving community health care."

Clearly, then, the educational process was every bit as important as the content of what was learned. Perhaps the process was more important, since the goal of CEP was not to produce experts in public health, but to encourage local residents to become informed participants in community health care decision making.

CEP worked in four low income communities where there was grassroots interest in health problems and where the University was invited by involved community residents to provide assistance. Two communities, Central Harlem and the Lower East Side, were located in Manhattan. The other two, Central Brooklyn-Crown Heights and Williamsburg-Greenpoint, were located in Brooklyn. Because of its proximity to Columbia University and because of the community's previous contacts with the school of Public Health, CEP started its first courses in Harlem in fall 1972 and continued to work there until September, 1974.

Of the 18 courses and workshops supported between 1972 and 1974, nine were given in Central Harlem, five in Williamsburg-Greenpoint, three in the Lower East Side, and one in Central Brooklyn-Crown Heights. The total

number of separate individuals who participated was 332. Of these, a significant proportion (58.3%) took more than one course.

The process of program development was similar in each community. After contact had been established between CEP and interested community groups (usually at the initiative of the community), a general meeting of community residents was widely publicized (through notices, flyers sent to local organizations, etc.) to discuss local health care problems and the need for community health education. At the open meeting the general purpose of the CEP project was explained, the community was invited to react, and finally, after a period of discussion, agreement was reached on the need for community health education courses. An important outcome of the open meeting was the formation of a "steering committee" of community volunteers to undertake the task of assessing learning needs and objectives and planning a course for community residents.

The course steering committee was a crucial component of CEP's community education strategy. In each case, the local committee, with the aid of CEP staff, made the major decisions about course goals, topics for individual sessions, and recruitment of learners and faculty members. Most steering committees consisted of six to eight members, although one in Harlem had only two members, while another in the Lower East Side had 14. The planning process typically required about six weeks, with the average committee meeting once a week in two to three hour sessions. Following the planning period, usually at its last meeting, the steering committee designated one of its members to serve as course coordinator. As noted earlier, the coordinator was responsible for the week to week conduct of the course, e.g., contacting prospective faculty, introducing speakers, serving as discussion leader.

According to CEP staff, the community steering committees were responsible for all decisions concerning the courses, the CEP providing advice or assistance when asked. There was a reported tendency for community groups to be wary of the University initially and to rely minimally on CEP for assistance. Later, when greater trust developed, CEP staff had to resist a tendency for steering committees to turn over their responsibilities to the university "experts."

The products of the local steering committees efforts were a variety of courses and workshops with widely divergent objectives and learning formats, and of varying intensity and duration. (The course outlines are found in Appendix C.) Weekend workshops on such topics as nutrition and proposal writing tended to be highly focused and logically structured. Some of the longer conventional courses were also characterized by a single underlying theme, such as the Williamsburg-Greenpoint course dealing with the organization and administration of health care systems (sample topics: Administrative Structure of Health Agencies; Hospital Structure; the Medicaid System). Other courses, such as the 19 session Central Brooklyn-Crown Heights course of December '73 to February '74, consisted of a smorgasbord of topics with no discernible rationale or structure, e.g., Communication Skills, Emergency Health Services, Patient's Rights, Drug Abuse, Nutrition, Preventative Medicine. A novel program of three special workshops was labelled "Train the Trainers." The purpose of these intensive courses was to train community residents in the skills needed to do what CEP was doing, namely to serve as resource persons or teachers for community health education and health improvement efforts.

It was mentioned above that the steering committees were responsible not only for planning the courses, but for selecting faculty and recruiting

"students." According to CEP staff, the committees' main criterion in selecting faculty was to "get the best person possible," for a particular topic. Faculty members tended not to be academics, but representatives of health consumer advocacy agencies or spokesmen for various segments of the health care planning and delivery (provider) establishment. Over time, a core group of a dozen faculty resource people emerged, mostly individuals who were lively teachers and "really knew their thing." Only one of these "regulars" held a university appointment. The others represented such diverse organizations as the New York State Health Planning Commission and Mobilization for Youth Legal Services.

Students were recruited in a variety of ways, sometimes with great vigor, sometimes not. Probably the single most important source of participants were community agencies and groups concerned in some way with health care. About 32% of the students were providers, i.e., employees of hospitals and other health care agencies; the majority, however, were consumers, local residents with an interest in health problems. According to CEP staff, participants tended to be active in community organizations and typically were middle aged women, middle class in outlook, and of minority racial or ethnic background. Our own limited classroom observations supported this characterization of the "typical" participant. It should be stressed, however, that participant backgrounds varied considerably, especially outside Harlem.

CEP's community development approach necessarily resulted in the creation of a broad range of learning experiences reflecting needs and priorities as defined by each of the four local communities. CEP, then, can best be viewed not as a unitary program of consumer health education, but as a process of community education which resulted in a variety of

different programs to hopefully meet the needs of different communities. The common thread in all this activity was the overall objective of helping adults to be informed and active participants in community health care decision making.

Intended Practice: Program Goals

This section recapitulates program intent: what CEP seriously and realistically intended to accomplish. The above description of the program, which was based on project documents and interviews with CEP staff, also illuminates intended practice. But in this section we define more explicitly the major program goals articulated by CEP staff that served as the basis for discrepancy analysis.

A general systems framework provides a useful way of ordering program intents. For most educational programs, the basic inputs are participants, faculty, and other resources such as facilities. The throughput consists of some sort of educational process which transforms inputs into outputs. Output is generally enhanced knowledge and skills and perhaps their application in problem solving situations.

Interviews with CEP staff revealed that the overriding intended output was a corps of participants who were aware of and knowledgeable about community health care problems and issues and who had become actively involved in applying their learning to improving health care in their communities. Successful attainment of this objective was intended in the long run to produce health consumer leadership and a community based consumer "constituency" for this leadership.

These output objectives were to be achieved through a process best described as community development through education. As noted previously, it was assumed that adults learn best when they take responsibility for

their own learning. Consequently, the two key process objectives were active involvement by community members in assessing community needs and designing programs and in implementing programs once they had been planned. By placing responsibility for establishing the classes in the hands of the participants it was hoped that they would have an opportunity to practice the organizing skills essential for community action. The idea was to give the participants a sense of potency--to demonstrate to them that it was their responsibility to achieve change and that they could indeed do so.

More concretely, the instructional process was intended to:

- increase awareness of community health care problems and issues
- enhance knowledge and understanding of community health problems and the nature of the health care delivery system
- help participants identify alternative courses of action to improve health care in their communities
- teach the skills needed for effective action to improve community health care.

Intended program participants were opinion leaders and potential opinion leaders from low income communities plagued by health problems and inadequate health care services. It was expected that some participants would come from established community agencies interested in health care, that others would come from organizations that provide health care, and that a third group would be comprised of those without organizational affiliation who were concerned about health care issues and problems.

The steering committees were expected to take major responsibility for selecting faculty, and thus CEP staff had no expectation of setting criteria to insure "high standards." Nevertheless, it was anticipated by CEP that faculty would be "the best available" in their area of expertise

and would be able to relate well or "get across" to the community participants.

Key program intents are summarized below in a very rough systems framework.

Summary of Program Intent

<u>Input</u>	<u>Intent</u>
Students	Students should be opinion leaders and potential opinion leaders from communities plagued with health problems and inadequate health care services. They should volunteer to participate.
Faculty	Faculty should be selected by the steering committee, should be very knowledgeable of their subject matter, and should relate well to the participants.
<u>Process</u>	
Program Planning and Implementation	Community residents, through a course steering committee and course coordinator, should take the major responsibility for assessing community needs, designing and implementing courses.
Learning	The learning experience should aim at increased awareness of health care problems and issues, enhanced knowledge and understanding of community health problems and the nature of the health care system, ability to identify alternative courses of action to improve health in the community, and skills needed for effective action to improve community health care.
<u>Output</u>	
Change in Participants	Participants should acquire the skills and knowledge necessary to improve health care in their communities. Further, they should become more involved in efforts to improve health care or ameliorate health problems in their communities.

Actual Practice: The Survey Results

Profile of Participants

Of the 115 respondents, 36 (31.3%) were employed in health-related jobs, almost exclusively at the paraprofessional, clerical, or technical level. Half a dozen described themselves as community health workers or aides, several were technicians, clerks, and licensed practical nurses. One directed a family planning clinic, another a nursing home. A handful were registered nurses. There were no physicians, hospital administrators, or public health officials among the "provider" participants. The "consumer" participants seemed fairly representative of low income community residents. Several described themselves as community organizers, others were school aides, bookkeepers, students, blue collar workers, and housewives.

When asked to indicate their main reason for participation in CEP, about two-thirds responded "to increase my knowledge of the health care system so I can work effectively to change or improve it." Approximately one-fourth checked "I was interested in health care problems in my community and wanted to learn more about the subject." Only 13 individuals said they attended because of jobs with "a community program, agency, or organization concerned with health care." Participants employed in the health field were equally as likely as others to want to "change or improve" the system.

About three-fifths of the respondents reported they had taken more than one course. Of this group, about half participated in two courses and half in three or more courses. Those not employed in the health field were equally as likely as providers to have taken two or more courses.

Perceptions of Educational Process

Participants were asked: "How much say did community members have in deciding what your Consumer Education Course would be like?" Of those who responded to the item (104), 28% indicated that community members had the greatest say. About 60% said the University and the community had about equal say, and the remainder, about one in eight, said the University had the greatest say.

A second, related question, asked: "Who took most of the responsibility for organizing and running the Consumer Education Course?" The distribution of responses was similar. About 20% indicated community; 60% indicated equal responsibility between University and community; and 20% indicated University. Employment in the health field, number of courses taken, and motivation for participation were not related to perceptions concerning who had the most say in deciding what the course would be like and who had greatest responsibility for organizing and running the course. In short, then, about eight out of ten respondents said that the community, or the community jointly with the University, took the major responsibility for planning and implementing the CEP courses they attended.

Perceptions of Educational Outcomes

Participants were asked: "How much did you learn about community health problems as a result of your participation in the Consumer Education Program?" Only 8.7% indicated they learned little they didn't know before. 32.2% said they learned some things they didn't know before, and 59.1% said they learned many things they didn't know before.

A related question asked: "How much did you learn about the organization and workings of the health care delivery system in your community as

a result of the Consumer Education Program?" 10% indicated "little," 35% "some," and 55% "a great deal." Not surprisingly, only 40% of those employed in the health field said they learned a great deal, compared with 62.5% of the consumer group ($\chi^2=6.6$, $df=2$, $p<.05$). Also not surprisingly, a larger proportion of those who took two or more courses reported learning a great deal (62.5% compared to 44.4%, $\chi^2=9.0$, $df=2$, $p<.02$).

Respondents were also asked: "To what degree, if any, did the Consumer Education Program improve your ability to participate effectively in community health care decision making?" About 13% reported that CEP helped little; 40% reported it helped some; and 45% reported it helped a great deal. There was a substantial difference on this item between those who took only one course and those who took two or more courses. Only 25.5% of the former group reported that the course "helped a great deal to improve my ability to participate effectively," compared with 61.5% of the latter group ($\chi^2=14.4$, $df=2$, $p<.001$).

Respondents were asked whether, before they participated in CEP, they were "actively involved in any community group, organization, or agency that was at least partly concerned with community health care problems." A second question asked if they were currently involved in any such group or organization. 85.4% indicated involvement before participation in CEP and 78.2% said they were actively involved at the time they completed the questionnaire. Overall, then, participation in CEP appeared to have no effect on active membership in community health organizations -- a large majority were already involved before participating in CEP. However, it is interesting to note that those employed in the health field reported greater participation after the course (91.4%) than did health consumers, of whom 71.2% reported participation in health

organizations following CEP ($\chi^2=4.5$, $df=1$, $p<.05$). Moreover, 85.9% of those who took two or more courses reported participation in health organizations following CEP, compared with 67.4% of those who took only one course ($\chi^2=4.4$, $df=1$, $p<.05$).

Another question, focused explicitly on application of knowledge and skills gained in CEP, asked: "As a result of your participation in the Consumer Education Program, have you become more involved in community health affairs?" A follow-up question asked those responding affirmatively to "explain in a few words how or in what way you have become more involved in community health affairs." 57.4% said they had become more involved in community health affairs because of CEP. Of those who took two or more courses, 71% responded affirmatively to this question compared with only 39.1% of those who took one course ($\chi^2=9.7$, $df=1$, $p<.01$). Interestingly, those who said that they participated in CEP in order to "change or improve" the system did not report greater participation in community health affairs than those who enrolled for other, perhaps less militant motives. Nor was greater participation related to employment in the health field. Of those who reported greater involvement as a result of CEP, three-fourths gave some kind of relevant response to the question of "how or in what way." Listed below are representative responses to this question.

- active in evaluating medical centers in community
- encourage people in community to seek proper health care
- attend more meetings in community
- able to give more information on health problems as block worker
- joined community health group
- joined two ambulatory care committees

- joined organization to get funds for health education programs
- joined Harlem Steering Committee
- volunteered to work in hospital
- ran for community board of local hospital
- joined hospital committee
- work with drug programs
- working for community dental services
- joined hospital advisory board
- organizing mothers to help retarded kids
- more effective in health-related job (mentioned several times)
- became chairman of health organization committee
- trying to better health conditions in neighborhood
- joined comprehensive dental health committee

A final question related to application of knowledge and skills asked: "To what degree, if any, did your participation in the Health Consumer Education Program prepare you to teach others in your community about health care problems and issues?" About a fourth indicated that they felt "well prepared to teach others"; two-thirds said they felt "somewhat prepared, but not well prepared;" and the remainder indicated that they did not feel "at all prepared to teach others." Interestingly, those who took two or more courses did not feel any better prepared to teach others than did those who took only one course. Moreover, participants in special "Train the Trainers' workshops designed to train community health resource persons were no more likely than others to report being "well prepared" to teach.

One universal measure used to evaluate courses and programs is the question, "would you recommend it to others?" On this criterion, CEP comes off very well indeed. Only one respondent indicated he would not

recommend the course or courses he took to others in the community. Seven indicated "maybe." Everyone else responded "yes."

The final item on the questionnaire asked for suggestions about how the program might be improved. About two-fifths made relevant comments of one kind or another. Several suggested more "field work" (e.g., trips to agencies, observation of meetings), and one individual recommended "community based projects for practical application of learnings." A number of respondents commented to the effect that CEP should make a greater effort to recruit people in the community not involved in the health field. Others suggested that the program could benefit from wider, more vigorous publicity.

Actual Practice: Interview Data

The following description of actual practice is based on in-depth interviews with four course coordinators and one student who was very active in planning CEP courses. The student was interviewed in lieu of a fifth coordinator, because the coordinator for the course was unavailable for an interview. Interviews generally lasted from one to two hours.

For most course participants, the initial contact with CEP came through the recruitment process. This process is best described as diffuse. Announcement of an initial meeting of those who might be interested in community health problems was filtered through the community by notifying community agencies, by word-of-mouth, and, in some cases, through announcements in community newspapers and newsletters and by distributing flyers. It is interesting to note that, in the majority of cases, those interviewed were not clear about how they had been recruited. They obviously had learned of the impending program, but they did not remember just how or where.

At the initial organizational meeting, the CEP program was explained. Participants were told that they would have the major say in determining course content and selecting instructors. They were also told that they were to select a course coordinator and a steering committee to plan for the courses.

The selection process for coordinators was a consensual one. No formal votes were taken. Persons who were vocal, had experience in community organization work, knew something of the health care delivery system, and were willing to serve were generally drafted for the position. All the coordinators interviewed possessed most or all of the above characteristics, and none were very clear about how they had become coordinators. The general feeling was "I just fell into it."

The participants themselves seemed to be a diverse group. Some were from organizations which provided health care, some were from community agencies focusing on health care, and some were merely concerned citizens. The ratio varied from community to community.

Once a coordinator and a course steering committee had been selected, and once a core of participants had been identified, the next step was to determine course content, establish meeting times and dates, and to select instructors. In this process, those with knowledge of and past experience with health care problems seemed to have the greatest say. Although the decision making process seemed to be firmly under the control of the participant steering committees, the input of the CEP staff apparently had greater weight than that of the steering committee members. This is understandable since the CEP staff were more experienced and knowledgeable in the health care field. Even though the Columbia team's input of expertise was greater than that of the participants, the course coordinators

all seemed to feel that authority for decision making rested with the participants. The fact that course topics were quite similar in each of the five communities is further evidence of the magnitude of CEP staff input.

Instructors for the courses were suggested by the steering committee members and the CEP staff. It was the general consensus that the quality of instruction was excellent, though in each case there were instructors who were less well received than others. Instructors who were well received at one course site were often asked to instruct at other course sites. In every case the classes seemed to focus on the major hospital in the community. In the case of the Harlem courses, classes were actually conducted in Harlem Hospital. Two topic areas which seemed to elicit particular praise were "communications" and "proposal writing."

As previously explained, the basic model employed by CEP might be described as community development through adult education. The idea was that interested students would be made more aware of health care problems and would be equipped with the knowledge and skills to solve them. Awareness, knowledge and skills were to lead to action. All interviewed saw great benefits to this approach, especially in comparison with the confrontational-political approach which has been often employed in disadvantaged urban communities. Interviewees felt that learning how health care organizations operate enabled community residents to work with health care providers toward common solutions rather than working at cross purposes. One respondent remarked, for example, "I feel you don't destroy something you cannot rebuild. You have to work with institutions, not against them." Another stated that the approach eliminated the "grinding wheel for people with axes." All those interviewed

seemed to feel that the program did supply the knowledge and skills needed for community residents to work within the system for positive change.

Yet, though the basic approach received accolades from the respondents, only one could give concrete examples of organized involvement with community health issues that continued after the classes had terminated. In this case several course participants had banded together in an effort to get an alternative slate of candidates elected to the community hospital's advisory board. To say, however, that there is little evidence of organized involvement is not to say there has been no involvement. Often, evidence of involvement takes time to manifest itself and the courses have ended only recently. Also, our survey data show strong evidence that there has been considerable individual involvement with community health care problems and issues.

Nevertheless, most respondents expressed a wish that there had been more organized action as a result of the courses. Three of the four felt that the recruitment process should have been more selective -- that recruitment should have been focused on community leaders predisposed to organized action. Most interviewed also felt that there should have been a follow-up phase to the CEP program during which action groups would have been organized and supported in their activities.

The program was supposed to be open to anyone who wished to participate. All evidence seems to indicate that this intent was realized. Yet, as some of those interviewed pointed out, an open door approach, whatever the benefits, creates certain problems. Not all participants were highly committed to the learning objectives of the course. In one community, for example, a large number of paraprofessionals from the local hospital attended. The course coordinator from that community felt that these

persons were often a disruptive influence because they attended in the belief that participation would impress their superiors and enhance promotion possibilities, not because they wished to improve health care in the community. Whether or not our respondent's assessment is warranted, it does seem probable that differences in the way participants related to this particular course caused some tension among students. It is likely, however, that the problems associated with this class were atypical.

Open ended enrollment seemed to have produced considerable diversity among students in regard to educational level. This diversity made the instructor's role somewhat difficult in some cases. Our respondents, for example, indicated that in every course sequence there were instructors who either talked above or below them. Nevertheless, the coordinators felt that most instructors managed to gear their presentations so that those at different educational levels could benefit. Talking above or below the majority of the class was the exception rather than the rule.

Two of those interviewed participated in the Train the Trainer sessions. The purpose of this component of CEP was to equip selected participants of the regular classes with the skills and knowledge to teach others what they had learned in the regular classes and in the Train the Trainer sessions. We were unable to secure much information regarding Train the Trainers. One respondent saw considerable value in the workshop she attended. Another felt that her particular Train the Trainer session, conducted at a weekend retreat, was not very worthwhile.

In general, those interviewed assessed the CEP program as very effective and beneficial. The picture of current practice we received from interview respondents seems largely consistent with intended practice as described earlier.

Comparison of Intended with Actual Practice

As explained in the section dealing with evaluation design, the basis for the present evaluation is a comparison between program intents and actual program practice. Intent was established by interviews with CEP staff. Actual practice was established through our survey of participants, examination of project documents, and through interviews with community course coordinators.

Intent 1 Students should be opinion leaders and potential opinion leaders from low income communities where the delivery of health care has been inadequate. Students should volunteer to participate.

We find no discrepancies in respect to this intent. Survey results indicate that, prior to taking part in the program, 85.4% of our respondents were actively involved in organizations concerned with health care issues. It is reasonable to assume that a significant number of these persons were opinion leaders in respect to community health care and in other areas, and that a significant number of those remaining were potential opinion leaders. Interview responses produced strong evidence that all course coordinators were opinion leaders within their respective communities. Recruitment was open ended, and as a result CEP had little direct control over who was recruited. A measure of control was achieved, however, by focusing initial publicity through existing community agencies involved in or concerned with health care. It is obvious that a majority of participants were recruited in this way. All those who participated in CEP volunteered to do so.

Courses were conducted in Harlem, the Lower East Side of Manhattan, Williamsburg-Greenpoint and Central Brooklyn. Each of these low income communities meets the criterion of inadequate community health care services.

Intent 2. Faculty should be selected by the course steering committee, should be very knowledgeable in their area of expertise, and should relate well to the participants.

That program faculty generally were knowledgeable in their areas of expertise and generally related well to participants is evidenced by the fact that 92% of our survey respondents indicated they would recommend the course(s) they took to others in their communities. Moreover, student ratings of each class session on "the way the guest speaker handled the session" were consistently positive for all courses in each of the four communities. The fact that general satisfaction was high, however, does not mean that there was unconditional and universal praise for all faculty members. The educational level of course participants was quite diverse, ranging from functional illiteracy to college completion. Hence, while in some classes participants felt they were being talked down to, in others participants felt the material was too difficult. In our opinion, however, the great majority of faculty members were apparently able to deal with the diversity problem, gearing their presentations to participants of varying sophistication and educational attainment. Occasionally, community political leaders who were invited to address classes failed to show, and occasionally participants reacted negatively to what one interview respondent termed a "patronizing attitude." Yet, nearly all these problems were to be expected in a program such as CEP, and nearly all were caused by circumstances over which CEP had little or no control. Faculty who were ill-received were not invited to instruct other classes, and faculty who were very effective were used many times and, in fact, came to constitute a "core" group of resource persons.

Although it is probably safe to say that community members did indeed retain the power to select faculty members, the process of selection

was shared with CEP staff. The steering committee had the final say, but CEP staff had considerable influence because they knew of, and had greater access to, a wider range of faculty resources than did the steering committees. In no instance did we find that CEP staff input was considered illegitimate or inappropriate.

Intent 3. Community residents, through a course steering committee, should take the major responsibility for assessing community needs and designing and implementing courses.

We find little discrepancy between this intent and actual practice. The planning process began with an open meeting which was publicized primarily by notifying community agencies active in the health field. In some cases, flyers were distributed and notices placed in community newspapers and agency newsletters. During the open meeting, CEP objectives were explained and those present were asked to form a course steering committee which would select course topics and faculty, set the time and place for the course, and choose a course coordinator. In addition to giving the participants the major say in planning instruction, the steering committee was intended to legitimize the course in the eyes of the community. The planning process itself was rather informal. Course coordinators, for example, were selected by consensus rather than by vote.

To say that the steering committee and other participants had responsibility for planning and implementation is not to say that they were the sole decision makers. Decision making requires knowledge of alternatives and implementation generally requires resources. The CEP staff possessed a certain expertise and certain resources that the steering committee did not. Consequently, their input to the decision making process was significant. About 28% of our survey respondents indicated that the community had the greatest say in deciding what the Consumer

Education Courses would be like; 68% indicated that the University and community had about equal say, and the remainder felt that the University had the greatest say. CEP staff members mentioned that the steering committees occasionally attempted to turn over responsibility to CEP, but these attempts were firmly resisted.

Even though CEP staff input to the decision making process was sometimes considerable, we uncovered no evidence that it was ever resented. In fact, one interview respondent criticized the CEP staff for not taking firm control of the decision making process. In our judgment, the role of the CEP staff in course planning and implementation could be best described as facilitative. Leadership was exercised, and necessarily so, but always in the interest of supporting community-initiated effort.

Intent 4. The learning process should aim at increased awareness of health care problems and issues, enhanced knowledge and understanding of community health problems and the nature of the health care system, ability to identify alternative courses of action to improve health in the community, and skills needed for effective action to improve community health care.

All evidence indicates that this intent was substantially realized. Examination of course descriptions shows that course subject matter was entirely consistent with the above intents. Generally, however, a particular course addressed itself to only one or two of the above goals. Proposal writing, for example, was principally addressed to upgrading "skills needed for effective action to improve health care." Hence, if a student failed to take more than one course, he would not have the opportunity to acquire the full range of knowledge and skills listed above. Survey results indicate that 41.7% of the participants took one course, 29.6% took two courses, and 28.7% took three or more courses. Therefore, more than half the total group were at least exposed to a wide range of learning experiences.

Intent 5. Participants should acquire the skills and knowledge necessary to improve health care in their communities. Further, they should become more involved in efforts to improve health care or ameliorate health problems in their communities.

It appears that, to a very considerable degree, these outcome intents were realized. We should note, however, that assessment of outcomes in an ex post facto evaluation is problematical. It cannot be asserted with complete confidence that the observed outcomes resulted solely or even mainly from the educational program. Furthermore, our measures of learning gains and behavioral change are based solely on participant self-reports. It was not possible for us to obtain pre-test/post-test scores to determine the amount of knowledge actually acquired. We are more confident, however, about the reliability and validity of self-reports of "increased involvement." Participants either became more involved as a result of CEP or they did not. We see no reason why their reports should not be, on the whole, reasonably accurate.

Two survey questions asked participants how much knowledge they had acquired as a result of CEP (knowledge of community health problems and knowledge of organization and workings of the health care system). Roughly, two-fifths said they had acquired a great deal of knowledge; only one in ten indicated they had learned little or nothing. Another question asked about improvement in "ability to participate effectively in community health decision making." Apparently, CEP was slightly less successful in achieving this intended outcome. Fewer than half (45%) reported that CEP "helped a great deal." Most of the remainder said CEP "helped some." In general, those who took two or more courses reported the greatest amount of learning.

Perhaps the most crucial question was the following: "As a result of your participation in the Consumer Education Program, have you become

more involved in community health affairs?" About half (57.4%) responded that they had become more involved as a result of CEP. This finding presents some ambiguities in interpretation. It may well be that many of those who did not respond affirmatively were already very actively involved and could not reasonably become more involved. We suspect that this was the case and that CEP was generally quite successful in achieving its primary goal of greater involvement by consumers in health care decision-making and community health care improvement activities. The quality, or meaningfulness, of this enhanced involvement was generally impressive. Responses to the open-ended item "how or in what way have you become more involved" indicated a wide range of significant activities. These are listed on pages 20-21.

Summary

Overall, we found a high degree of congruence between program intents as articulated by CEP staff and actual practice as determined by a survey of participants and in-depth interviews with course coordinators from the four communities involved. The lack of significant discrepancies does not make for a very interesting discrepancy analysis, which is probably more of a "disappointment" for the evaluators than for CEP's staff.

Not only do we find few discrepancies between intended and actual practice, but we have little quarrel with the appropriateness of program intents as formulated by CEP. In general, we feel that Columbia University's Health Consumer Education Program was soundly conceived and effectively implemented. It is heartening to find educators putting into practice in a competent, professional manner the tenets of adult education that are so widely endorsed in principle yet so seldom heeded in practice.

Although CEP was quite successful, insofar as we were able to reliably

gauge success, we believe that CEP's experience raises some questions that merit further thought and discussion. Accordingly, we offer the following recommendations to guide development of similar programs in the future, whether at Columbia University or elsewhere.

Recommendations

1. Focus Recruitment on Community Leaders

CEP encouraged anyone who was interested in health care problems and wanted to participate to do so. Although we feel that this was an important and commendable aspect of the program, we also feel that a more effective direct attack on health care problems could have resulted had the program recruited a greater number of participants who, by virtue of their demonstrated leadership in the community, could be expected to be predisposed to concerted action. Thus, while we would recommend that the program remain open to all (with perhaps less encouragement of heavy provider representation), we would also recommend that there be greater effort to recruit community residents with demonstrated leadership abilities. Many of these individuals would have valuable ties to local community action organizations. The Train the Trainers program was apparently a move in this direction; perhaps it should have been given higher priority.

2. Emphasize Application of Skills and Knowledge

CEP put a great deal of emphasis on the acquisition of knowledge through lectures and discussion, but relatively little emphasis on the application of knowledge and skills in problem solving situations. We recommend that ways be devised to permit participants to apply knowledge and skills out in the community under the guidance of CEP staff or other

qualified professionals. Students, for example, could be encouraged to participate in ongoing community health improvement projects. Periodically, they would be brought together for informal seminars to discuss their experiences and to probe the reasons for their successes and failures. Needed additional training could be provided by CEP. If lack of success were judged the result of improper application of skills or inadequate knowledge, steps could be taken to remedy the problem. Several respondents indicated on the questionnaire that CEP could be improved by more attention to non-classroom learning experiences, such as visits to health care agencies and observation of CEP meetings.

3. Provide Technical Assistance for Community Action Projects

In our opinion, CEP was quite successful in creating awareness of community health problems among its participants, and in some cases awareness led to direct action. We believe, however, that effective involvement and real change in community health conditions would be greatly enhanced if CEP were to add a technical assistance phase to its educational component. In the technical assistance phase, individuals and groups that decided to actively work for health care improvement would be supported in their efforts with needed professional expertise. We are not saying that the University itself should organize direct action programs, but that the University should make its resources available to community groups that need assistance. In some cases, direct technical assistance could cause "political" problems for the University. Such problems might be minimized by channeling technical assistance through linkages with community health improvement agencies. Experience in community development has shown that education in itself is usually not sufficient to bring about fundamental institutional change. Some form of follow-up technical

assistance is almost always necessary.

4. Institute Continuous Program Evaluation from Inception of Program

After-the-fact evaluations, such as this one, have limited utility for improving programs; they also have built-in methodological shortcomings. Ideally, evaluation should begin at the inception of the program and should be geared to providing information to improve the program, to help redirect it, as it unfolds over time. The opportunity that continuous program evaluation provides for securing comprehensive, reliable and valid data are obvious. Continuous, formative evaluation is expensive, but if done well it is worth the price.

APPENDIX A

School of Public Health
Columbia University

CONSUMER EDUCATION IN COMPREHENSIVE HEALTH PLANNING QUESTIONNAIRE

Directions

Please answer all questions. Check only one box ☒ for each question, or if you prefer, write the answer in your own words. Please don't be kind to us if we don't deserve it. Your criticisms will help us to do a better job in the future. Your answers will be kept confidential. Do not sign your name.

- | | | |
|---|--|-----|
| 1. How many Consumer Health Education courses did you participate in? | ☐ One course | 1 |
| | ☐ Two courses | () |
| | ☐ Three or more courses | |
| 2. How much say did community members have in deciding what your Consumer Education Course would be like?
(Check only one box) | ☐ Community members had the greatest say about what the course would be like | 2 |
| | ☐ Community members and Columbia University staff had about equal say | () |
| | ☐ Columbia University staff had the greatest say | |
| 3. Who took most of the responsibility for organizing and running the Consumer Education Course? (Check only one box) | ☐ Community members took most of the responsibility for organizing and running the course | 3 |
| | ☐ Columbia University staff and community members took about equal responsibility | () |
| | ☐ Columbia University staff took most of the responsibility | |
| 4. How much did you learn about community health problems as a result of your participation in the Consumer Education Program? (Check only one box) | ☐ I learned little that I didn't know before about health problems | 4 |
| | ☐ I learned some things I didn't know before about health problems | () |
| | ☐ I learned many things I didn't know before about health problems | |

- OVER -

5. How much did you learn about the organization and workings of the health care delivery system in your community as a result of the Consumer Education Program? (Check only one box)
- ☐ I learned little I didn't know before about the health care delivery system 5 ()
- ☐ I learned some things I didn't know before about the health care delivery system
- ☐ I learned a great deal that I didn't know before about the health care delivery system
6. To what degree, if any, did the Consumer Education Program improve your ability to participate effectively in community health care decision making? (Check only one box)
- ☐ The program did little to improve my ability to participate effectively in health care decision making 6 ()
- ☐ The Program helped some to improve my ability to participate effectively
- ☐ The Program helped a great deal to improve my ability to participate effectively
7. Before you first participated in the Consumer Health Education Program, were you actively involved in any community group, organization, or agency that was at least partly concerned with community health care problems?
- ☐ Yes 7 ()
- ☐ No
8. Are you actively involved now in any community group, organization, or agency that is at least partly concerned with community health care problems?
- ☐ Yes 8 ()
- ☐ No
9. Which one statement below best describes your own reason for participating in the Health Consumer Education Program? (Check only one box)
- ☐ I was interested in health care problems in my community and wanted to learn more about the subject 9 ()
- ☐ I attended because of my job with a community program, agency, or organization concerned with health care
- ☐ I wanted to increase my knowledge of the health care system so I could work effectively to change or improve it
- ☐ Other reason (please describe) _____

10. As a result of your participation in the Health Consumer Education Program, have you become more involved in community health affairs? ☐ Yes 10
☐ No ()
11. If you answered Yes to Question 10, please explain in a few words how or in what way you have become more involved in community health affairs. 11
()

12. To what degree, if any, did your participation in the Health Consumer Education Program prepare you to teach others in your community about health care problems and issues? (Check only one box) 12
()
- ☐ I feel well prepared to teach others in my community about health care problems and issues
- ☐ I feel somewhat prepared, but not well prepared, to teach others in my community about health care problems and issues
- ☐ I do not feel at all prepared to teach others in my community about health care problems and issues
13. Would you recommend the course or courses you took to others in the community? ☐ Yes 13
☐ Maybe ()
☐ No
14. Please describe briefly the kind of work you usually do (for example: nurse's aide, machinist, housewife, accountant). 14
()

15. If you have any suggestions about how the Health Consumer Education Program can be improved or if you would like to make any other comments, please write them below. 15
()

THANK YOU FOR YOUR COOPERATION

APPENDIX B

COLUMBIA UNIVERSITY
SCHOOL OF PUBLIC HEALTH of the Faculty of Medicine

CONTINUING EDUCATION
Telephone: 212-568-4334

21 Audubon Avenue
New York, N.Y. 10032

July 17, 1974

Dear Consumer Education Course Participant:

The Continuing Education staff of the Columbia University School of Public Health is sponsoring a study of the Consumer Education in Comprehensive Health Planning programs it co-sponsored with community groups in Harlem, The Lower East Side, Williamsburg-Greenpoint and Central Brooklyn.

The purpose of this study is to determine how successful the program has been in meeting the needs of communities for consumer health education and to obtain information that will help us to improve our programs in the future.

We have enclosed a short questionnaire that should take only a few minutes to complete. We would appreciate it if you would fill it out and return it to us as soon as possible in the enclosed, stamped envelope.

Your answers to the questionnaire will be kept completely confidential. You do not have to sign your name.

To do a really good study, we need the cooperation of everyone who participated in the courses. Please return the questionnaire today, if you can. We deeply appreciate your cooperation in this study.

Sincerely,



Marcia Pinkett Heller, M.P.H.
Instructor, Health Administration



Isaac Purdue
Project Assistant